Louisiana Wing Cadet Programs
Encampment Application

PRINT IN CAPITAL LETTERS

Complete the following pages as completely and accurately as possible. Illegible or incomplete applications will be returned to the Squadron Commander.

NAME (Last, First, MI)			JOINED CAP (MM/YY)	
CAPID	CAP GRADE	CHARTER	REGION	STATE
MAILING ADDRESS (Number and Street)				
(City)		(State)	(Zip Code)	
DATE OF BIRTH (MM/DD/YY)	HEIGHT / WEIGHT	GENDER	HAIR	EYES
RELIGIOUS PREFERENCE	E-MAIL ADDRESS			
OCCUPATION OR GRADE IN SCHOOL				

OFFICE USE ONLY

DATE RECEIVED: _____

PAYMENT: _____

FORMS:

☐ Application

☐ Medical

☐ Hold Harmless

TELEPHONE:

HOME: (____) _____

OTHER: (____) _____

Flight Member ☐

OR

Staff ☐

(Indicate Staff Position Desired)

Prior Encampment Completion is required for staff

1) _____

2) _____

T-Shirt (Adult Sizes)

_____ Small _____ Medium _____ XX-Large

_____ Large _____ X-Large _____ XXX-Large

SQUADRON CERTIFICATION

I verify that I have reviewed this application with the applicant and that it is accurate to the best of my knowledge.

Squadron Commander _____

You must obtain all signatures as indicated. Please note that witnesses for parent signatures must be a non-CAP member over the age of 21.

Mail your completed application packet along with the appropriate fee to:

Louisiana Wing Summer Encampment
3130 Claycut Rd.
Baton Rouge, LA 70806-6804

Please make checks payable to Louisiana Wing, CAP

MEDICAL INFORMATION AND RELEASE FORM - TO BE COMPLETED BY ALL APPLICANTS

This information is for Official Use Only and will not be released to unauthorized persons. Answer all questions as accurately as possible so that encampment staff can make themselves aware of any pre-existing medical problems or conditions.

NAME (Last, First, MI) | CAPID

DO YOU CURRENTLY USE ANY MEDICATION? (including eye drops or over the counter)

☐ NO ☐ YES (List any medication taken and the reason in the remarks section)

ARE YOU ALLERGIC TO ANY MEDICATION?

☐ NO ☐ YES (List any medication allergic to in the remarks section)

HAVE YOU HAD OR BEEN INVOLVED IN AN ACCIDENT IN THE PAST 2 YEARS?

☐ NO ☐ YES (Explain the extent of your injuries and treatment required in the remarks section)

HAVE YOU HAD OR HAVE NOW ANY OF THE FOLLOWING? (If yes is answered on any items, please explain in the remarks section with dates and physician(s) consulted (if any). Items not specifically noted below having the potential to interfere with the performance during the encampment should be documented in the remarks section.)

☐ NO ☐ YES Heat related Illness	☐ NO ☐ YES High or Low blood pressure	☐ NO ☐ YES Any known allergies
☐ NO ☐ YES Frequent or severe headaches	☐ NO ☐ YES Stomach trouble	☐ NO ☐ YES Chronic or recurring injuries
☐ NO ☐ YES Dizziness or fainting spells	☐ NO ☐ YES Asthma	☐ NO ☐ YES Chronic diseases like Diabetes, Bronchitis
☐ NO ☐ YES Unconsciousness for any reason	☐ NO ☐ YES Ear infections	☐ NO ☐ YES Females only - Menstrual cramps
☐ NO ☐ YES Eye trouble, excluding glasses	☐ NO ☐ YES Epilepsy or seizures	☐ NO ☐ YES Other illness or accidents
☐ NO ☐ YES Hay fever	☐ NO ☐ YES Kidney stones or blood in urine	☐ NO ☐ YES Admission to hospital
☐ NO ☐ YES Sugar or albumin in urine	☐ NO ☐ YES Motion sickness	☐ NO ☐ YES Attempted Suicide
☐ NO ☐ YES Heart trouble	☐ NO ☐ YES Nervous trouble of any sort	☐ NO ☐ YES Medical treatment within the past 5 years other than regular office visits or physicals

FAMILY PHYSICIAN (Name, address, and phone number)

INSURANCE INFORMATION

Medical Insurance Plan — Company

Policy Number and/or Group Number

MANDATORY

EMERGENCY CONTACT - PARENT, GUARDIAN, OR CLOSEST RELATIVE TO BE NOTIFIED IN THE CASE OF EMERGENCY

Name — Relationship

Address — Day Telephone — Night Telephone

REMARKS AND/OR ADDITIONAL INFORMATION

I, _____

☐ being the parent(s) of the above described person

☐ being the legal guardian of the above described person

hereby give full authorization to any Medical Doctor, Medical Clinic and/or Hospital to administer emergency medical services to the above described person. This authorization is only valid on Civil Air Patrol activities.

SIGNED _____ DATE _____

RELEASE INDEMNIFICATION AND HOLD HARMLESS AGREEMENT

In consideration of being allowed to participate in a Civil Air Patrol Encampment at Barksdale AFB, Louisiana on 19-29 June 2003, and sponsored by the United States Air Force, I hereby agree to assume full responsibility for my own safety and indemnity, save and hold harmless the Government of the United States and of its employees and agents, acting officially or otherwise, from any and all liability, claims, demands, actions, debts, and attorney fees arising out of, claimed on account of, or in any manner predicated on a loss or damage to the property of and injuries to, or death of any persons whatsoever, which may occur resulting from my presence within the limits of Barksdale AFB in connection with the aforesaid program, do hereby waive forever any demands or claims thereof.

Date

Signature of Participant

Printed Name of Participant

Parent or legal guardian must sign for all participants under the age of 18

Address	
Home Phone	Work Phone
Cell Phone	Any Additional Contact Information

Date

Signature of Parent/Guardian

Printed Name of Parent/Guardian

Date

Witness to Parent/Guardian Signature

Printed Name of Witness

PRINT OR TYPE ALL INFO

HEADQUARTERS
CIVIL AIR PATROL
UNITED STATES AIR FORCE AUXILIARY
8550 LLOYD STEARMAN DR., SUITE 118
NEW ORLEANS, LOUISIANA 70126-8034

MEDICAL RELEASE FORM

NAME _____ CAPSN _____ CHARTER_____
(LAST NAME, FIRST NAME, MI)

EYE COLOR_____ HAIR COLOR _____ HEIGHT _____ WEIGHT_____

ADDRESS _____ CITY_____ STATE ____

ZIP CODE _____ HOME TELEPHONE _____ DOB _____

PARENTS WORK PHONE _____ EXTENSION _____

NEAREST RELATIVE _____ PHONE _____

NEAREST NEIGHBOR _____ PHONE _____

FAMILY DOCTOR _____ PHONE _____

MEDICAL INSURANCE PLAN _____

GROUP NUMBER _____ CONTRACT NUMBER _____

BLOOD TYPE _____

MEDICATIONS ALLERGIC TO _____

MEDICATIONS CURRENTLY TAKING_____

ANY OTHER PERTINENT INFORMATION YOU WOULD CONSIDER IMPORTANT

_____

_____

I, _____

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( ) being the legal guardian of the above described person

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SIGNED _____ DATE _____

LA CAP FORM 43, MAR 96